

\_\_\_\_\_ School District  
**Individual Education Program**

Page 1

|  |                                      |   |  |
|--|--------------------------------------|---|--|
| Student Name <input type="checkbox"/> Male <input type="checkbox"/> Female   | Meeting Date                         | Purpose of Meeting<br><input type="checkbox"/> Initial Eligibility, IEP, Placement<br><input type="checkbox"/> Annual Review of IEP<br><input type="checkbox"/> Three Year Reevaluation<br><input type="checkbox"/> Dismissal from Services Date: _____<br><input type="checkbox"/> Parent Request<br><input type="checkbox"/> Other: _____   |  |
| Student Information Management System (SIMS) Number  | Age                      Grade       |   |  |
| Date of Birth  | Date Services Begin                  | Discussed evaluation results/progress/assessment method<br><input type="checkbox"/> Yes      ____ (Parent/Guardian initial)<br><br>Copy of evaluation results received <input type="checkbox"/> Yes      ____ (Parent initial)  |  |
| School of Residence  | Annual Review Date                   | <b>*Transition Planning Needed</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes (If yes, attach applicable transition pages.)  |  |
| Attendance Center  | Parent/Guardian Name, Address, Phone | Student is eligible for special education or special education and related services as determined by the IEP team<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>An annual copy of Parent/Guardian Rights was received and reviewed<br>_____ (Date)      _____ (Parent/Guardian Initial)  |  |
| Date of Multidisciplinary Evaluation   | Hm:                      Wk:         |   |  |
| Three Year Reevaluation Due  | Parent/Guardian Name, Address, Phone | A copy of the IEP was provided to parent/guardian<br><input type="checkbox"/> Yes      _____ (Parent/Guardian Initial)  |  |
|  | Hm:                      Wk:         |   |  |
| <b>IEP Team Membership</b>   | <b>Signature</b>                     | <b>Date</b>   |  |
| Parent/Guardian  |                                      |   |  |
| Parent/Guardian  |                                      |   |  |
| Student  |                                      |   |  |
| Superintendent/Designee  |                                      |   |  |
| General Classroom Teacher  |                                      |   |  |
| Special Education Teacher  |                                      |   |  |
| Speech/Language Pathologist  |                                      |   |  |
| Evaluator  |                                      |   |  |
| Title  |                                      |   |  |
| Title  |                                      |   |  |
| Title  |                                      |   |  |
| <b>Child Count Information (District Option to Complete)</b><br>Disabling Condition<br><input type="checkbox"/> 0500 <input type="checkbox"/> 0505 <input type="checkbox"/> 0510 <input type="checkbox"/> 0515 <input type="checkbox"/> 0525 <input type="checkbox"/> 0530 <input type="checkbox"/> 0535<br><input type="checkbox"/> 0540 <input type="checkbox"/> 0545 <input type="checkbox"/> 0550 <input type="checkbox"/> 0555 <input type="checkbox"/> 0560 <input type="checkbox"/> 0555 <input type="checkbox"/> 0570<br><br><div style="text-align: center;"> <b>Ethnicity</b> _____<br/> <b>W B I H A O</b> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;">           A. Minutes per week in Special Education<br/>           B. Minutes per week in Related Services         </div> <div style="width: 45%; text-align: center;"> <div style="display: flex; justify-content: space-around;"> <div> <u>Minutes</u><br/>           _____<br/>           _____<br/>           _____         </div> <div> <u>Services</u><br/>           _____<br/>           _____<br/>           _____         </div> </div> </div> </div> <div style="margin-top: 10px;"> <b>C. A + B = (Total minutes of Special Education/Related Services)</b>      _____         </div> |                                      | <b>Placement</b><br><input type="checkbox"/> 0100 Regular Classroom with Modification<br><input type="checkbox"/> 0110 Resource Room<br><input type="checkbox"/> 0120 Self-Contained Classroom<br><input type="checkbox"/> 0130 Day Program Code: _____<br><input type="checkbox"/> 0140 24 Hour Program Code: _____<br><input type="checkbox"/> 0150 Home/Hospital<br><input type="checkbox"/> 0315 Early Childhood Setting 80-100%<br><input type="checkbox"/> 0325 Early Childhood Setting 40-79%<br><input type="checkbox"/> 0330 Early Childhood Setting 0-39%<br><input type="checkbox"/> 0335 Separate Class<br><input type="checkbox"/> 0345 Separate School<br><input type="checkbox"/> 0355 Residential Facility<br><input type="checkbox"/> 0365 Home<br><input type="checkbox"/> 0375 Service Provider Location |  |
| Parent/Guardian declines all special education services  |                                      |   |  |
| Parent/Guardian Signature: _____   |                                      |   |  |

\_\_\_\_\_ School District  
**Individual Education Program**

**Page 1**

|   |                                      |   |
|---|--------------------------------------|---|
| Student Name <input type="checkbox"/> Male <input type="checkbox"/> Female                  | Meeting Date                         | Purpose of Meeting<br><input type="checkbox"/> Initial Eligibility, IEP, Placement<br><input type="checkbox"/> Annual Review of IEP<br><input type="checkbox"/> Three Year Reevaluation<br><input type="checkbox"/> Dismissal from Services Date: _____<br><input type="checkbox"/> Parent Request<br><input type="checkbox"/> Other: _____ |
| Student Information Management System (SIMS) Number   | Age                      Grade       |   |
| Date of Birth   | Date Services Begin                  | Discussed evaluation results/progress/assessment method<br><input type="checkbox"/> Yes      ____ (Parent/Guardian initial)<br><br>Copy of evaluation results received <input type="checkbox"/> Yes      ____ (Parent initial)  |
| School of Residence   | Annual Review Date                   | <b>*Transition Planning Needed</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes (If yes, attach applicable transition pages.)  |
| Attendance Center   | Parent/Guardian Name, Address, Phone | Student is eligible for special education or special education and related services as determined by the IEP team<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><br>An annual copy of Parent/Guardian Rights was received and reviewed<br>_____ (Date)      _____ (Parent/Guardian Initial)                                |
| Date of Multidisciplinary Evaluation  | Hm:                      Wk:         |   |
| Three Year Reevaluation Due   | Parent/Guardian Name, Address, Phone | A copy of the IEP was provided to parent/guardian<br><input type="checkbox"/> Yes      ____ (Parent/Guardian Initial)   |
|   | Hm:                      Wk:         |   |
| <b>IEP Team Membership</b>  | Signature                            | Date  |
| Parent/Guardian   |                                      |   |
| Parent/Guardian   |                                      |   |
| Student   |                                      |   |
| Superintendent/Designee   |                                      |   |
| General Classroom Teacher   |                                      |   |
| Special Education Teacher   |                                      |   |
| Speech/language Pathologist   |                                      |   |
| Evaluator   |                                      |   |
| Title   |                                      |   |
| Title   |                                      |   |
| Title   |                                      |   |
| Title   |                                      |   |
| Title   |                                      |   |
| Title   |                                      |   |
| Title   |                                      |   |
| Title   |                                      |   |
| Title   |                                      |   |
| Parent/Guardian declines all special education services<br>Parent/Guardian Signature: _____ |                                      |   |

Based on evaluation, include academic achievement and functional performance (**strengths and weaknesses**) in the areas affected by the student's disability, including transition in the IEP to be in effect when the student turns 16; **parent concerns**; and how the student's disability affects the student's **involvement and progress in the general education curriculum**. (For a preschool child, how the disability affects his/her participation in appropriate activities.)

|                      |                  |
|----------------------|------------------|
| <b>Student Name:</b> | <b>IEP Date:</b> |
|                      |                  |

**\* Remember to address:**

- Skill or Transition Area
- Strengths & Needs
- How the student's disability affects his/her involvement/progress in the general education curriculum for the skill area
- Parent input

**Is the student limited English proficient?** ☐ Yes ☐ No

If the answer to this question is "yes", please explain the language needs of the student as these needs relate to the student's IEP.

---

---

---

**Are there any special communication needs?** ☐ Yes ☐ No

If the answer to this question is "yes", what direct instruction will be provided in the student's mode of communication?

---

---

---

**Does the student require Braille?** ☐ Yes ☐ No

If the answer to this question is "yes", what Braille services will be provided?

---

---

---

**Does the student's behavior impede his or her learning or that of others?** ☐ Yes ☐ No

If yes, what strategies are required to appropriately address this behavior, including positive behavioral interventions and supports?

---

---

---

---

---

---

---

---

**Physical Education:** ☐ Regular ☐ Not Required ☐ Adaptive: Refer to Goals/Goals & Objectives

**Hearing Aid Maintenance:** ☐ Not Applicable ☐ Yes: Personnel Responsible for Monitoring \_\_\_\_\_

Describe the monitoring process/frequency necessary for maintenance: \_\_\_\_\_

---

---

### Assessment

1. ☐ Student will be taking state and district wide assessments with or without accommodations. (Accommodations will be determined on page 7.) (Annual goals required)
2. ☐ Student will be taking an alternate assessment (The alternate assessment is for students working in the alternate achievement standards) (Annual goal and short term objectives required)
  - a. Yes – No - Does the student meet the criteria for significant cognitive disability? (If no, student is not eligible to take alternate assessment.)
  - b. Explain the reason why the student cannot participate in the regular assessment. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
  - c. Explain the reason why the alternate assessment selected is appropriate for this student \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
3. ☐ State and/or district-wide assessments are not required at this student's grade level during the course of this annual IEP.

**(Required on or before the student's 16th birthday)** note: The term "Measurable Postsecondary Goals" replaces "Life Planning Outcomes" (What does the student plan to do after high school?) – Current OSEP guidance requires at least one linked annual goal **AND** at least one service/activity for each MPSG identified. Assessment results should determine which MPSGs are addressed.

Employment: \_\_\_\_\_  
 \_\_\_\_\_ (See linked annual goal(s) # \_\_\_\_\_)

Education: \_\_\_\_\_  
 \_\_\_\_\_ (See linked annual goal(s) # \_\_\_\_\_)

Training: \_\_\_\_\_  
 \_\_\_\_\_ (See linked annual goal(s) # \_\_\_\_\_)

Independent Living: (where appropriate) \_\_\_\_\_  
 \_\_\_\_\_ (See linked annual goal(s) # \_\_\_\_\_)

### Transition Courses of Study

**(Required on or before the student's 16th birthday)** (Complete for the current school year through the planned exit year)  
 (Should relate to and help the student to progress towards achievement of the Measurable Postsecondary Goals listed above)

| Grade | Grade | Grade | Grade | Grade |
|-------|-------|-------|-------|-------|
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

Comments: \_\_\_\_\_  
 \_\_\_\_\_

### Transfer of Parent/Guardian Rights (Must be addressed on or before the 17<sup>th</sup> birthday).

Student will turn 17 on \_\_\_\_\_. Student was informed of this transfer of rights on \_\_\_\_/\_\_\_\_/\_\_\_\_\_.

### Graduation or Completion of an Approved Program (Must be addressed at least one year prior to graduation date.)

Student is to graduate/complete program: (Date) \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Individualized district specific requirements and remaining courses needed to complete an approved secondary education program:

### Summary of Performance – (For students who are graduating with a regular diploma or aging out of special education)

A summary of the child's academic achievement & functional performance, which shall include recommendations on how to assist the child in meeting the child's postsecondary goals, is required. A suggested form and instructions are available on the SEP web site.

**One Year Follow-Up – (For students who are graduating, aging out, or dropped out)** Students will be contacted one year after exiting, by a contract agency, to determine their status in regards to employment, postsecondary school, and other outcomes.

## Transition Services / Coordinated Set of Activities

Page 4B

These 7 categories are from section 300.42 of IDEA 2004

\*Transition Services must be a coordinated set of Activities/Strategies designed within a results oriented process. This means that the activities are those steps or things that need to happen that will lead to post-school results and help the student achieve their desired post secondary goals. All of the activities that will need to happen to help students achieve their post secondary goals cannot be done by the school alone. Thus, the activities should include those things that others (students, families and the appropriate adult services, agencies or programs) will need to do. When viewed as a whole, the activities should demonstrate involvement and coordination between schools, students, families and the appropriate adult services, agencies or programs.

---

### Instruction:

| <u>Activity Recommendations</u> | <u>Personnel/Agency/Person Responsible</u> | <u>Date Initiated</u> | <u>Date Completed</u> |
|---------------------------------|--|-----------------------|-----------------------|
|---------------------------------|--|-----------------------|-----------------------|

---

### Related Services:

| <u>Activity Recommendations</u> | <u>Personnel/Agency/Person Responsible</u> | <u>Date Initiated</u> | <u>Date Completed</u> |
|---------------------------------|--|-----------------------|-----------------------|
|---------------------------------|--|-----------------------|-----------------------|

---

### Community Experiences:

| <u>Activity Recommendations</u> | <u>Personnel/Agency/Person Responsible</u> | <u>Date Initiated</u> | <u>Date Completed</u> |
|---------------------------------|--|-----------------------|-----------------------|
|---------------------------------|--|-----------------------|-----------------------|

---

### Employment:

| <u>Activity Recommendations</u> | <u>Personnel/Agency/Person Responsible</u> | <u>Date Initiated</u> | <u>Date Completed</u> |
|---------------------------------|--|-----------------------|-----------------------|
|---------------------------------|--|-----------------------|-----------------------|

---

### Other Post-School Adult Living Objectives:

| <u>Activity Recommendations</u> | <u>Personnel/Agency/Person Responsible</u> | <u>Date Initiated</u> | <u>Date Completed</u> |
|---------------------------------|--|-----------------------|-----------------------|
|---------------------------------|--|-----------------------|-----------------------|

---

### Acquisition of Daily Living Skills (When appropriate):

| <u>Activity Recommendations</u> | <u>Personnel/Agency/Person Responsible</u> | <u>Date Initiated</u> | <u>Date Completed</u> |
|---------------------------------|--|-----------------------|-----------------------|
|---------------------------------|--|-----------------------|-----------------------|

---

### Functional Vocational Evaluation (When appropriate):

| <u>Activity Recommendations</u> | <u>Personnel/Agency/Person Responsible</u> | <u>Date Initiated</u> | <u>Date Completed</u> |
|---------------------------------|--|-----------------------|-----------------------|
|---------------------------------|--|-----------------------|-----------------------|

|  |              |  |                      |   |
|--|--------------|--|----------------------|---|
| Student Name   |              | Title of Personnel Responsible   |                      |   |
| Measurable Annual Goal #_____  | Proc. Code/s | Date   | Prog. Code           | Comments:   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
| Short Term Instructional Objectives or Benchmarks<br>(Required for students who take alternate assessments aligned to alternate achievement standards.)  | Proc. Code/s | Date   | Prog. Code           | Comments:   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
|  |              |  |                      |   |
| Accommodations/Modifications/Supplementary Aides and Services  |              |  | Frequency & Duration | Location  |
| 1. _____   |              |  | _____                | _____   |
| 2. _____   |              |  | _____                | _____   |
| 3. _____   |              |  | _____                | _____   |
| 4. _____   |              |  | _____                | _____   |
| 5. _____   |              |  | _____                | _____   |
| Statement of the program modifications or supports for school personnel (as appropriate):  |              |  | Frequency & Duration | Location  |
|  |              |  |                      |   |
| <b>Procedure Codes (Complete at IEP meeting)</b><br>1. Teacher-made tests      6. Work Samples<br>2. Observations            7. Portfolios<br>3. Weekly tests              8. Oral Tests<br>4. Unit tests                 9. Data Response<br>5. Student Conferences    10. Other: |              | <b>Progress Codes</b><br><b>P</b> = Progress being made<br><b>I</b> = Insufficient Progress to meet goal<br><b>X</b> = Not addressed this Reporting Period<br><b>M</b> =Met goal |                      | <b>Reporting Frequency to Parents</b><br><input type="checkbox"/> Quarterly Reports<br><input type="checkbox"/> Trimester Reports <input type="checkbox"/> Other: _____<br><b>Reporting Method to Parents</b><br><input type="checkbox"/> Conferences <input type="checkbox"/> Report Card<br><input type="checkbox"/> Goal Page Copy <input type="checkbox"/> Other: |

### Related Services To Be Provided

| Title of Personnel Responsible  | Description | Amount of Services, and Location |
|---|-------------|----------------------------------|
| <input type="checkbox"/> <b>A. Occupational Therapy</b>   |             |                                  |
| <input type="checkbox"/> <b>B. Physical Therapy</b>   |             |                                  |
| <input type="checkbox"/> <b>C. Psychological Services</b>   |             |                                  |
| <input type="checkbox"/> <b>D. Counseling Services</b>  |             |                                  |
| <input type="checkbox"/> <b>E. Social Work Services</b>   |             |                                  |
| <input type="checkbox"/> <b>F. Audiological Services</b>  |             |                                  |
| <input type="checkbox"/> <b>G. Recreation Therapy</b>   |             |                                  |
| <input type="checkbox"/> <b>H. School Nurse Services</b>  |             |                                  |
| <input type="checkbox"/> <b>I. Speech/Language Therapy</b>  |             |                                  |
| <input type="checkbox"/> <b>J. Transportation</b> (Specify when, how often, where, distance, costs, etc.) |             |                                  |
| <input type="checkbox"/> <b>K. Other</b>  |             |                                  |
| <input type="checkbox"/> <b>L. Assistive Technology</b>   |             |                                  |
| <input type="checkbox"/> <b>M. Orientation and Mobility</b>   |             |                                  |
| <input type="checkbox"/> <b>N. Medical Services</b> (Diagnostic Services only)                            |             |                                  |
| <input type="checkbox"/> <b>O. Interpreting Services</b>  |             |                                  |
| <input type="checkbox"/> <b>P. Parental Counseling/Training</b>   |             |                                  |

### State/District Assessment Accommodations

1. ☐ Student will be taking the assessment without accommodations.
2. ☐ Student will be taking the assessment with the accommodations and/or modifications.

**\*\*\*Teams must consider if the accommodations and or modifications are approved for the applicable test administration.**

**\*\*\*List the accommodations and/or modifications the student will be taking for each test/test area.**

(Only those accommodations and or modifications identified for instruction can be considered for state and district wide testing. Teams must also consider if the accommodations and or modifications are approved for the applicable test administration)

Grades 3-4-5-6-7-8-11

**Dakota Step**

Reading

---

---

---

---

Math

---

---

---

---

Grades 5-8-11

Science

---

---

---

Grades 5 & 9

**Stanford**

Writing

---

---

---

---



---

---

---

---



---

---

---

District Specific Tests

**Name:**

Area(s)

---

---

---

---



---

---

---

---



---

---

---



---

**\* Alternate Assessment**

**All accommodations/modifications documented in the IEP shall be used as needed for alternate assessment.**

| Continuum of Alternative Placements |  | Continuum of Alternative Placements (Ages 3-5) |                                      |
|-------------------------------------|--|--|--------------------------------------|
| <input type="checkbox"/>            | 0100 Regular Classroom with Modification | <input type="checkbox"/>                       | 0315 Early Childhood Setting 80-100% |
| <input type="checkbox"/>            | 0110 Resource Room                       | <input type="checkbox"/>                       | 0325 Early Childhood Setting 40-79%  |
| <input type="checkbox"/>            | 0120 Self-Contained Classroom            | <input type="checkbox"/>                       | 0330 Early Childhood Setting 0-39%   |
| <input type="checkbox"/>            | 0130 Day Program Code: _____             | <input type="checkbox"/>                       | 0335 Separate Class                  |
| <input type="checkbox"/>            | 0140 24 Hour Program Code: _____         | <input type="checkbox"/>                       | 0345 Separate School                 |
| <input type="checkbox"/>            | 0150 Home/Hospital                       | <input type="checkbox"/>                       | 0355 Residential Facility            |
|                                     |  | <input type="checkbox"/>                       | 0365 Home                            |
|                                     |  | <input type="checkbox"/>                       | 0375 Service Provider Location       |

[illegible]**Participation with Non-Disabled Peers (Complete for all students Ages 6-21)**

|  |  |                         |
|--|--|-------------------------|
| <b>Program Options</b><br><input type="checkbox"/> Art <input type="checkbox"/> Vocational Education<br><input type="checkbox"/> Industrial Technology <input type="checkbox"/> Family & Consumer Science<br><input type="checkbox"/> Music <input type="checkbox"/> Other |  | <b>Comments</b><br><br> |
|  |  |                         |

|   |  |   |                 |
|---|--|---|-----------------|
| <input type="checkbox"/> Non-Academic<br><input type="checkbox"/> Counseling<br><input type="checkbox"/> Meals<br><input type="checkbox"/> Employment Referrals |  | <input type="checkbox"/> Recess<br><input type="checkbox"/> Health Services<br><input type="checkbox"/> Other _____ | <b>Comments</b> |
| _____   |  |   |                 |

|   |                        |
|---|------------------------|
| <p>Extracurricular</p> <div> <input type="checkbox"/> Athletics             <input type="checkbox"/> Recreation         </div> <div> <input type="checkbox"/> Clubs             <input type="checkbox"/> Other_____         </div> <div> <input type="checkbox"/> Groups         </div> | <p><b>Comments</b></p> |
|---|------------------------|

*Justification for Placement--An explanation of the extent, if any, to which the child will not participate with non-disabled children in regular classes, and non-academic activities. (Please use accept/reject format for each alternative placement considered.)*

☐ *The team addressed the potential harmful effects of the special education placement.*

**Extended School Year Services:** ☐ needed ☐ not needed ☐ to be determined by (Date) \_\_\_\_/\_\_\_\_/\_\_\_\_

| Goal(s) # | *Type of Service | Beginning Date<br>mm/dd/yy | Ending Date<br>mm/dd/yy | Minutes<br>Per Week | **Based on |
|-----------|------------------|----------------------------|-------------------------|---------------------|------------|
|           |                  |                            |                         |                     |            |
|           |                  |                            |                         |                     |            |
|           |                  |                            |                         |                     |            |
|           |                  |                            |                         |                     |            |
|           |                  |                            |                         |                     |            |
|           |                  |                            |                         |                     |            |
|           |                  |                            |                         |                     |            |
|           |                  |                            |                         |                     |            |
|           |                  |                            |                         |                     |            |

\* Instruction, related services (specify), other (list)

\*\* Regression/Recoupment, Emerging Skills, or Maintenance of Critical Life Skills

**Parent/Guardian Consent For Extended School Year Program only**

“Consent” means that the parent(s)/guardian(s) have been fully informed of all information relevant to the activity for which consent is sought, in the native language, or other mode of communication; the parent(s)/guardian(s) understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists any records which will be released and to whom; and the granting of consent by the parent(s)/guardian(s) is voluntary and may be revoked in writing at any time.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Parent/Guardian Consent Required For Initial Placement Only**

“Consent” means that the parent(s)/guardian(s) have been fully informed of all information relevant to the activity for which consent is sought, in the native language, or other mode of communication; the parent(s)/guardian(s) understand and agree in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists any records which will be released and to whom; and the granting of consent by the parent(s)/guardian(s) is voluntary and may be revoked in writing at any time.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Clarifying Comments:**

**Individual Education Plan Addendum**  
**Addendum to IEP dated \_\_\_\_/\_\_\_\_/\_\_\_\_**

|  |              |   |
|--|--------------|---|
| Student Name   | Meeting Date | Date of Birth   |
| <b>Purpose of Meeting</b><br><input type="checkbox"/> Parent Request<br><input type="checkbox"/> Other (Please specify):   |              | A copy of this IEP addendum was provided to parent/guardian<br><input type="checkbox"/> Yes ____ (Parent/Guardian Initial)  |
| IEP Team Membership  | Signatures   | Date  |
| Parent/Guardian  |              |   |
| Parent/Guardian  |              |   |
| Student  |              |   |
| Superintendent/Designee  |              |   |
| General Classroom Teacher  |              |   |
| Special Education Teacher  |              |   |
| Speech/Language Pathologist  |              |   |
| Evaluator  |              |   |
| Title  |              |   |
| Title  |              |   |
| Title  |              |   |
| <b>Child Count Information (District Option to Complete)</b><br>Disabling Condition<br><input type="checkbox"/> 0500 <input type="checkbox"/> 0505 <input type="checkbox"/> 0510 <input type="checkbox"/> 0515 <input type="checkbox"/> 0525 <input type="checkbox"/> 0530 <input type="checkbox"/> 0535<br><input type="checkbox"/> 0540 <input type="checkbox"/> 0545 <input type="checkbox"/> 0550 <input type="checkbox"/> 0555 <input type="checkbox"/> 0560 <input type="checkbox"/> 0555 <input type="checkbox"/> 0570<br><br><div style="text-align: right;">           Ethnicity _____<br/> <b>W B I H A O</b> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 40%;">             A. Minutes per week in Special Education<br/>             B. Minutes per week in Related Services<br/><br/>             C. <b>A + B = (Total minutes of Special Education/Related Services)</b> </div> <div style="width: 40%; text-align: center;"> <div style="display: flex; justify-content: space-around;"> <div style="border-bottom: 1px solid black; width: 100px;"></div> <div style="border-bottom: 1px solid black; width: 100px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="text-align: center;"><u>Minutes</u></div> <div style="text-align: center;"><u>Services</u></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="border-bottom: 1px solid black; width: 100px;"></div> <div style="border-bottom: 1px solid black; width: 100px;"></div> </div> <div style="display: flex; justify-content: space-around; margin-top: 5px;"> <div style="border-bottom: 1px solid black; width: 100px;"></div> <div style="border-bottom: 1px solid black; width: 100px;"></div> </div> </div> </div> |              | <b>Placement</b><br><input type="checkbox"/> 0100 Regular Classroom with Modification<br><input type="checkbox"/> 0110 Resource Room<br><input type="checkbox"/> 0120 Self-Contained Classroom<br><input type="checkbox"/> 0130 Day Program Code: _____<br><input type="checkbox"/> 0140 24 Hour Program Code: _____<br><input type="checkbox"/> 0150 Home/Hospital<br><input type="checkbox"/> 0315 Early Childhood Setting 80-100%<br><input type="checkbox"/> 0325 Early Childhood Setting 40-79%<br><input type="checkbox"/> 0330 Early Childhood Setting 0-39%<br><input type="checkbox"/> 0335 Separate Class<br><input type="checkbox"/> 0345 Separate School<br><input type="checkbox"/> 0355 Residential Facility<br><input type="checkbox"/> 0365 Home<br><input type="checkbox"/> 0375 Service Provider Location |

**Meeting Notes**

## IEP Addendum (Continued)

Student Name:

Meeting Date: